VIRGINIA DEPARTMENT OF HEALTH
Office of Licensure and Certification
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State Health Services Plan Task Force

Agenda
December 13, 2024 at 9:00 a.m.
VIA WEBEX

1. Call to Order and Welcome – Dr. Thomas Eppes, Jr., Chair
2. Roll Call
3. Review of § 32.1-102.2:1 of the Code of Virginia
4. Review of Agenda – Val Hornsby, Policy Analyst
5. Review of Meeting Materials
6. Approval of Prior Meeting Minutes
7. Public Comment Period

Break

8. The State Health Services Plan
    a. Presentation of feedback on the establishment of Guiding Principles for the SHSP – Val Hornsby, Policy Analyst
        i. Adoption of Guiding Principles for the SHSP
    b. Presentation of feedback on psychiatric services criteria – Erik Bodin, DCOPN Director
        i. Discussion & Voting on psychiatric service criteria for the SHSP
9. Wrap-Up and Next Steps
10. Meeting Adjournment

State Health Services Plan Task Force

December 13, 2024 Meeting

Roll Call

Review of § 32.1-102.2:1 of the Code of Virginia

§ 32.1-102.2:1. State Health Services Plan; Task Force.

A. The Board shall appoint and convene a State Health Services Plan Task Force for the purpose of advising the Board on the content of the State Health Services Plan. The Task Force shall provide recommendations related to (i) periodic revisions to the State Health Services Plan, (ii) specific objective standards of review for each type of medical care facility or project type for which a certificate of public need is required, (iii) project types that are generally non-contested and present limited health planning impacts, (iv) whether certain projects should be subject to expedited review rather than the full review process, and (v) improvements in the certificate of public need process. All such recommendations shall be developed in accordance with an analytical framework established by the Commissioner that includes a specific evaluation of whether State Health Services Plan standards are consistent with the goals of (a) meeting the health care needs of the indigent and uninsured citizens of the Commonwealth, (b) protecting the public health and safety of the citizens of the Commonwealth, (c) promoting the teaching missions of academic medical centers and private teaching hospitals, and (d) ensuring the availability of essential health care services in the Commonwealth, and are aligned with the goals and metrics of the Commonwealth's State Health Improvement Plan.

Review of the Agenda

Agenda

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Review of Meeting Materials

Approval of Prior Meeting Minutes

Public Comment Period

Public Comment Period

- There is a two-minute time limit for each person to speak
- After the two-minute public comment limit is reached, we will let you complete your sentence and move of to the next attendee

Break

The State Health Services Plan

Establishment of Guiding Principles for the SHSP

- The current SMFP guiding principles are outlined in 12VAC5-230-30 and are as follows:

1. The COPN program is based on the understanding that excess capacity or underutilization of medical facilities are detrimental to both cost effectiveness and quality of medical services in Virginia.
2. The COPN program seeks the geographical distribution of medical facilities and to promote the availability and accessibility of proven technologies.
3. The COPN program seeks to promote the development and maintenance of services and access to those services by every person who needs them without respect to their ability to pay.
4. The COPN program seeks to encourage the conversion of facilities to new and efficient uses and the reallocation of resources to meet evolving community needs.
5. The COPN program discourages the proliferation of services that would undermine the ability of essential community providers to maintain their financial viability.

Establishment of Guiding Principles Continued

- The 2018 State Medical Facilities Plan Task Force suggested, but did not adopt, the following proposed guiding principles:

6. The COPN program seeks to encourage the provision of services in the setting most appropriate to each patient; OR

6. The COPN program seeks to expand access to non-institution-owned sites of care. These independent sites will foster competition and should support the Institute for Healthcare Improvement (IHI) “Triple Aim” by:

• Improving the patient experience of care (including quality and satisfaction);
• Improving the health of populations; and
• Reducing the per capita cost of health care.

7. The COPN program seeks to encourage the development and implementation of innovative technologies that enhance and improve the quality, cost effectiveness, or both, in the delivery of health care services.

Establishment of Guiding Principles Continued

Proposed additions to Guiding Principles after solicitation of feedback:

1. The COPN program is based on the understanding that excess capacity or inappropriate ~~under~~utilization of ~~medical facilities~~ healthcare resources are detrimental to both cost effectiveness and the quality of medical services ~~in Virginia~~.
2. The COPN program seeks the geographical distribution of ~~medical facilities~~ health care resources, including proven technologies, ~~and~~ to promote their availability and accessibility ~~of proven technologies.~~
~~3. The COPN program seeks to promote the development and maintenance of services and access to those services~~ by every person who needs them without respect to their ability to pay.
4. The COPN program seeks to encourage the conversion of healthcare facilities to new and efficient uses and the reallocation of resources to meet evolving community needs.
5. The COPN program discourages the proliferation of services that would undermine the ability of essential community providers to maintain their financial viability.
6. Option 2 Addition to the Institute for Healthcare Improvements (IHI) "Triple Aim" by including:

- Reducing provider burnout; and
- Education of the next generation of physicians and providers.

VA Inpatient Psychiatric Beds Within a 30 & 60 Minute Drive

Psychiatric Services Criteria Feedback

Proposed additions to Psychiatric Services Criteria after solicitation of feedback:

- 12VAC5-230-840 Travel time - Instead of a drive time standard, there could be a preference for projects that would provide improved geographical distribution of licensed acute psychiatric services within a planning district in the need for new service section (under C).

- 12VAC-230-850.C. – Replacement of the current language to state that “Providers of acute psychiatric and acute substance abuse treatment should show evidence of providing or the intention to provide a continuum of community-based support services through ownership, partnership or contractual agreement.”

- 12VAC5-230-860.A. – Maintenance of current standards for licensed bed inventory and 75% occupancy rate.
- B. Suggestion - Exclusion of a preference for geriatric patients in PDs with an excess supply of beds.

Discussion

Wrap-Up and Next Steps

Meeting Adjournment

SHSP APA Exemption

§ 2.2-4006. Exemptions from requirements of this article.

A. The following agency actions otherwise subject to this chapter and § 2.2-4103 of the Virginia Register Act shall be exempted from the operation of this article:

16. Amendments to the State Health Services Plan adopted by the Board of Health following receipt of recommendations by the State Health Services Task Force pursuant to § 32.1-102.2:1 if the Board (i) provides a Notice of Intended Regulatory Action in accordance with the requirements of § 2.2-4007.01, (ii) provides notice and receives comments as provided in § 2.2-4007.03, and (iii) conducts at least one public hearing on the proposed amendments.

Chapter 230. State Medical Facilities Plan

12VAC5-230-30. Guiding principles in the development of project review criteria and standards.

The following general principles serve as the basis for the development of the review criteria and standards for specific medical care facilities and services contained in this document:

1. The COPN program is based on the understanding that excess capacity or underutilization of medical facilities are detrimental to both cost effectiveness and quality of medical services in Virginia.
2. The COPN program seeks the geographical distribution of medical facilities and to promote the availability and accessibility of proven technologies.
3. The COPN program seeks to promote the development and maintenance of services and access to those services by every person who needs them without respect to their ability to pay.
4. The COPN program seeks to encourage the conversion of facilities to new and efficient uses and the reallocation of resources to meet evolving community needs.
5. The COPN program discourages the proliferation of services that would undermine the ability of essential community providers to maintain their financial viability.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-100 § 3, eff. July 1, 1993; amended, Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-90. Travel time.

Article 1
Criteria and Standards for Computed Tomography

CT services should be within 30 minutes driving time one way under normal conditions of 95% of the population of the health planning district using a mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-100. Need for new fixed site or mobile service.

A. No new fixed site or mobile CT service should be approved unless fixed site CT services in the health planning district performed an average of 7,400 procedures per existing and approved CT scanner during the relevant reporting period and the proposed new service would not significantly reduce the utilization of existing

providers in the health planning district. The utilization of existing scanners operated by a hospital and serving an area distinct from the proposed new service site may be disregarded in computing the average utilization of CT scanners in such health planning district.

B. Existing CT scanners used solely for simulation with radiation therapy treatment shall be exempt from the utilization criteria of this article when applying for a COPN. In addition, existing CT scanners used solely for simulation with radiation therapy treatment may be disregarded in computing the average utilization of CT scanners in such health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-110. Expansion of fixed site service.

Proposals to expand an existing medical care facility's CT service through the addition of a CT scanner should be approved when the existing services performed an average of 7,400 procedures per scanner for the relevant reporting period. The commissioner may authorize placement of a new unit at the applicant's existing medical care facility or at a separate location within the applicant's primary service area for CT services, provided the proposed expansion is not likely to significantly reduce the utilization of existing providers in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; Errata, 25:11 VA.R. 2018 February 2, 2009.

12VAC5-230-120. Adding or expanding mobile CT services.

A. Proposals for mobile CT scanners shall demonstrate that, for the relevant reporting period, at least 4,800 procedures were performed and that the proposed mobile unit will not significantly reduce the utilization of existing CT providers in the health planning district.

B. Proposals to convert authorized mobile CT scanners to fixed site scanners shall demonstrate that, for the relevant reporting period, at least 6,000 procedures were performed by the mobile scanner and that the proposed conversion will not significantly reduce the utilization of existing CT providers in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-130. Staffing.

CT services should be under the direction or supervision of one or more qualified physicians.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part XII
Mental Health Services

Article 1
Acute Psychiatric and Acute Substance Abuse Disorder Treatment Services

12VAC5-230-840. Travel time.

Article 1
Acute Psychiatric and Acute Substance Abuse Disorder Treatment Services

Acute psychiatric and acute substance abuse disorder treatment services should be available within 60 minutes driving time one way under normal conditions of 95% of the population using mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-850. Continuity; integration.

A. Existing and proposed acute psychiatric and acute substance abuse disorder treatment providers shall have established plans for the provision of services to indigent patients that include:

1. The minimum number of unreimbursed patient days to be provided to indigent patients who are not Medicaid recipients;

2. The minimum number of Medicaid-reimbursed patient days to be provided, unless the existing or proposed facility is ineligible for Medicaid participation;

3. The minimum number of unreimbursed patient days to be provided to local community services boards; and

4. A description of the methods to be utilized in implementing the indigent patient service plan and assuring the provision of the projected levels of unreimbursed and Medicaid-reimbursed patient days.

B. Proposed acute psychiatric and acute substance abuse disorder treatment providers shall have formal agreements with the appropriate local community services boards or behavioral health authority that:

1. Specify the number of patient days that will be provided to the community service board;

2. Describe the mechanisms to monitor compliance with charity care provisions;

3. Provide for effective discharge planning for all patients, including return to the patient's place of origin or home state if not Virginia; and

4. Consider admission priorities based on relative medical necessity.

C. Providers of acute psychiatric and acute substance abuse disorder treatment serving large geographic areas should establish satellite outpatient facilities to improve patient access where appropriate and feasible.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-860. Need for new service.

A. The combined number of acute psychiatric and acute substance abuse disorder treatment beds needed in a health planning district with existing acute psychiatric or acute substance abuse disorder treatment beds or both will be determined as follows:

((UR x PROPOP)/365)/.75

Where:

UR = the use rate of the health planning district expressed as the average acute psychiatric and acute substance abuse disorder treatment patient days per population reported for the most recent five-year period; and

PROPOP = the projected population of the health planning district five years from the current year as reported in the most recent published projections by a demographic entity as determined by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

For purposes of this methodology, no beds shall be included in the inventory of psychiatric or substance abuse disorder beds when these beds (i) are in facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services; (ii) have been converted to other uses; (iii) have been vacant for six months or more; or (iv) are not currently staffed and cannot be staffed for acute psychiatric or substance abuse disorder patient admissions within 24 hours.

B. Subject to the provisions of 12VAC5-230-70, no additional acute psychiatric or acute substance abuse disorder treatment beds should be authorized for a health planning district with existing acute psychiatric or acute substance abuse disorder treatment beds or both if the existing inventory of such beds is greater than the need identified using the above methodology.

Preference may also be given to the addition of acute psychiatric or acute substance abuse beds dedicated for the treatment of geriatric patients in health planning districts with an excess supply of beds when such additions are

justified on the basis of the specialized treatment needs of geriatric patients.

C. No existing acute psychiatric or acute substance disorder abuse treatment beds should be relocated unless it can be reasonably projected that the relocation will not have a negative impact on the ability of existing acute psychiatric or substance abuse disorder treatment providers or both to continue to provide historic levels of service to Medicaid or other indigent patients.

D. The combined number of acute psychiatric and acute substance abuse disorder treatment beds needed in a health planning district without existing acute psychiatric or acute substance abuse disorder treatment beds will be determined as follows:

((UR x PROPOP)/365)/.75

Where:

UR = the use rate of the health planning region in which the health planning district is located expressed as the average acute psychiatric and acute substance abuse disorder treatment patient days per population reported for the most recent five-year period;

PROPOP = the projected population of the health planning district five years from the current year as reported in the most recent published projections by a demographic entity as determined by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

E. Preference may be given to the development of needed acute psychiatric beds through the conversion of unused general hospital beds. Preference will also be given to proposals for acute psychiatric and substance abuse beds demonstrating a willingness to accept persons under temporary detention orders (TDO) and that have contractual agreements to serve populations served by community services boards, whether through conversion of underutilized general hospital beds or development of new beds.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part II
Diagnostic Imaging Services
Article 1
Criteria and Standards for Computed Tomography (CT)

12VAC5-~~230~~XXX-90. Travel time for CT services.

CT services should be within 30 minutes driving time one way under normal conditions of 95% of the population of the health planning district using a mapping software and population data reported by a demographic entity as determined by the commissioner.

12VAC5-~~230~~XXX-100. Need for new fixed site CT service~~or mobile service~~.

A. ~~No~~ A new fixed site ~~or mobile~~ CT service ~~should~~ may be approved ~~unless~~ if: ~~fixed site~~

1. CT services, both fixed site and prorated mobile sites, in the health-planning district performed an average of 7,400 or more diagnostic procedures per existing and approved CT scanner during the relevant reporting period; and

2. the proposed new service would not ~~significantly~~ reduce the utilization of existing providers in the ~~health planning~~health-planning district below an average of 7,000 diagnostic procedures.

B. The utilization of existing scanners operated by a hospital and serving an area distant and distinct from the proposed new service site may be disregarded in computing the average utilization of CT scanners in such ~~health planning~~health-planning district.

B. Existing CT scanners used solely for simulation with radiation therapy treatment or for other image guided therapeutic treatments or applications shall be exempt from the utilization criteria of this article when applying for a COPN.

C. In addition, existing CT scanners used solely for simulation with radiation therapy or other image guided therapeutic treatments or applications may be disregarded in computing the average utilization of CT scanners in such ~~health planning~~health-planning district.

C. A new freestanding fixed site outpatient CT service may be approved if:

1. freestanding fixed site and mobile site CT services in the health-planning district performed an average of 5,000 or more procedures per existing and approved outpatient CT scanner during the relevant reporting period; and

2. the proposed new outpatient service would not reduce the average utilization of existing outpatient providers in the health-planning district to below 4,000. The utilization of scanners operated by an existing provider and serving an area or a clinical need distinct from the proposed new service site may be disregarded in computing the average utilization of CT scanners in such health-planning district.

D. A fixed site CT scanner service not owned or controlled by an institution may be approved when there is not an alternative to an institution-owned fixed site CT scanner service within 30 minutes or 30 miles of the institution-owned fixed site CT scanner service.

12VAC5-~~230~~XXX-110. Expansion of fixed site CT service.

A. ~~Proposals to expand an existing medical care facility's CT service through the addition of a CT scanner should~~The -commissioner may~~be~~ approve~~d~~ a proposal to expand an existing medical care facility's CT service through the addition of a CT scanner ~~when~~ if:

1. the existing ~~services~~ CTs at the applicant's medical care facility performed an average of ~~7,400~~9,000 or more procedures per scanner for the relevant reporting period~~.~~; and

2. ~~The commissioner may authorize placement of a new unit at the applicant's existing medical care facility or at a separate location within the applicant's primary service area for CT services, provided~~ the proposed expansion is not likely to significantly reduce the utilization of other existing providers in the health-planning district.

B. The commissioner may authorize placement of an additional CT at a separate~~location~~ site, owned or controlled by the applicant, within the applicant's primary service area for CT services, provided the proposed expansion is not likely to significantly reduce the utilization of existing providers in the health-planning district. Specific consideration will be given by the Commissioner to whether or not there is a non-institution owned CT scanner within 30 minutes or 30 miles of the existing medical care facility CT service before an expansion of a fixed site service is authorized.

C. Existing CT scanners used solely for simulation with radiation therapy treatment or for other image guided therapeutic treatments or applications shall be exempt from the utilization criteria of this article. ~~In addition,~~

D. ~~e~~Existing CT scanners used solely for simulation with radiation therapy or other image guided therapeutic treatments or applications may be disregarded in computing the average utilization of CT scanners in such health-planning district.

12VAC5-~~230~~XXX-120. ~~Adding or expanding mobile~~ Mobile CT ~~services~~sites.

A. Proposals for mobile CT scanner sites should demonstrate that, for the relevant reporting period, at least 1,000 patients were referred from the proposed site for CT imaging and that the proposed mobile CT site will not significantly reduce the utilization of existing providers in the health-planning district.

B. Proposals for a mobile CT scanner site shall demonstrate that, for the relevant reporting period, ~~at least~~an average of ~~4,800~~7,400 or more procedures were performed by all CT scanners in the

health planning district, including prorated mobile sites, and that the proposed mobile unit site will not significantly reduce the utilization of existing CT providers in the health-planning district.

CB. Proposals to convert authorized mobile CT scanner sites to fixed site scanners shall demonstrate that, for the relevant reporting period, at least 6,000 procedures were performed by at the mobile scanner site and that the proposed conversion will not significantly reduce the utilization of existing CT providers in the health planning district.

D. Existing CT scanners used solely for simulation with radiation therapy treatment or for other image guided therapeutic treatments or applications may be disregarded in computing the average utilization of CT scanners in such health-planning district.

E. Applications for new CT scanners to be used solely for simulation with radiation therapy treatment or for other therapeutic treatments or applications shall likewise be exempt from the utilization criteria of this article.

12VAC5-230XXX-130. Staffing for CT sites.

CT services should be under the direction or supervision of one or more qualified physicians.shall be staffed in accordance with 12VAC5-481-1591.

Part XII
Mental Health Services
Article 1
Acute Psychiatric and Acute Substance Abuse Disorder Treatment Services

12VAC5-~~230~~XXX-840. Travel time.
Acute psychiatric and acute substance abuse disorder treatment services should be available within 60 minutes driving time one way under normal conditions of 95% of the population of the health planning region using mapping software and population data reported by a demographic entity as determined by the commissioner.

12VAC5-~~230~~XXX-850. Continuity; integration.

A. Existing and proposed acute psychiatric and acute substance abuse disorder treatment providers shall have established plans for the provision of services to indigent patients that include:

1. The minimum number of unreimbursed patient days to be provided to indigent patients who are not Medicaid recipients;

2. The minimum number of Medicaid-reimbursed patient days to be provided, unless the existing or proposed facility is ineligible for Medicaid participation;

3. The minimum number of unreimbursed patient days to be provided to local community services boards; and

4. A description of the methods to be utilized in implementing the indigent patient service plan and assuring the provision of the projected levels of unreimbursed and Medicaid reimbursed patient days.

B. Proposed acute psychiatric and acute substance abuse disorder treatment providers shall have formal agreements with or endorsement from the appropriate local community services boards or behavioral health authority that:

1. Specify the number of patient days that will be provided to the community service board;

2. Describe the mechanisms to monitor compliance with charity care provisions;

3. Provide for effective discharge planning for all patients, including return to the patient's place of origin or home state if not Virginia; and

4. Consider admission priorities based on relative medical necessity.

C. Providers of acute psychiatric and acute substance abuse disorder treatment serving large geographic areas should establish satellite outpatient facilities to improve patient access where appropriate and feasible.

12VAC5-~~230~~XXX-860. Need for new service.

A. The combined number of acute psychiatric and acute substance abuse disorder treatment beds needed in a health-planning district with existing acute psychiatric or acute substance abuse disorder treatment beds or both will be determined as follows:

((UR x PROPOP)/365)/0.75

Where:

UR = the use rate of the health planning district expressed as the average acute psychiatric and acute substance abuse disorder treatment inpatient days attributed to patients whose primary residence is in the planning district per population of the planning district reported for the most recent five-year period; and

PROPOP = the projected population of the health planning district five years from the current year as reported in the most recent published projections by a demographic entity as determined by the Commissioner. ~~of the Department of Mental Health, Mental Retardation and Substance Abuse Services.~~

For purposes of this methodology, no beds shall be included in the inventory of psychiatric or substance abuse disorder beds when these beds (i) are in facilities operated by the ~~Department of Mental Health, Mental Retardation and Substance Abuse Services~~ Department of Behavioral Health and Developmental Services.; (ii) have been converted to other uses; or (iii) ~~have been vacant for six months or more~~were listed as not being staffed on the most recent VHI annual report~~; or (iv) are not currently staffed and cannot be staffed for acute psychiatric or substance abuse disorder patient admissions within 24 hours~~. Approved but not yet operational beds are included in the inventory.

B. Subject to the provisions of 12VAC5-~~230~~XXX-70, no additional acute psychiatric or acute substance abuse disorder treatment beds should be authorized for a health planning district with existing acute psychiatric or acute substance abuse disorder treatment beds or both if the existing inventory of such beds is greater than the need identified using the above methodology. Preference may also be given to the addition of acute psychiatric or acute substance abuse beds dedicated for the treatment of geriatric patients in health planning districts with an excess supply of beds when such additions are justified on the basis of the specialized treatment needs of geriatric patients.

C. No existing acute psychiatric or acute substance disorder abuse treatment beds should be relocated unless it can be reasonably projected that the relocation will not have a negative impact on the ability of existing acute psychiatric or substance abuse disorder treatment providers or both to continue to provide historic levels of service to Medicaid or other indigent patients.

D. The combined number of acute psychiatric and acute substance abuse disorder treatment beds needed in a health-planning district without existing acute psychiatric or acute substance abuse disorder treatment beds will be determined as follows:

((UR x PROPOP)/365)/0.75

Where:

UR = the use rate of the health planning region in which the health planning district is located expressed as the average acute psychiatric and acute substance abuse disorder treatment inpatient days per population of the health planning district reported for the most recent five-year period;

PROPOP = the projected population of the health planning district five years from the current year as reported in the most recent published projections by a demographic entity as determined by the Commissioner. ~~of the Department of Mental Health, Mental Retardation and Substance Abuse Services.~~

E. Preference may be given to the development of needed acute psychiatric beds through the conversion of unused general hospital beds. Preference will also be given to proposals for acute psychiatric and substance abuse beds demonstrating a willingness to accept persons under temporary detention orders (TDO) and that have contractual agreements to serve populations served by community services boards, whether through conversion of underutilized general hospital beds or development of new beds.

State Health Services Plan Task Force

November 18, 2024

Time 9:00 a.m.

Board Room 1, 9960 Mayland Drive

Henrico, Virginia 23233

Task Force Members in Attendance (alphabetical by last name): Jeannie Adams; Karen Cameron; Carrie Davis; Michael Desjadon; Paul Dreyer; Amanda Dulin; Dr. Thomas Eppes, Jr.; Paul Hedrick; Shaila Menees; Dr. Marilyn West.

Staff in Attendance (alphabetical by last name): – Erik O. Bodin, COPN Director, VDH OLC; Joseph Hilbert, Deputy Commissioner of Governmental and Regulatory Affairs, VDH; Val Hornsby, Policy Analyst, VDH OLC; Dr. Karen Shelton, State Health Commissioner, VDH.

1. **Call to Order and Welcome**

   Dr. Thomas Eppes, Jr. called the meeting to order at 9:03 a.m.

2. **Roll Call**

   Val Hornsby called the roll of the Task Force members. Mr. Hornsby noted that Dr. Baker, Dr. Berger, Mr. Elliott, Mr. Orsini, and Mr. Phillips were absent from the meeting.

3. **Review of § 32.1-102.2:1 of the Code of Virginia**

   Mr. Hornsby reviewed the mandate for the Task Force in § 32.1-102.2:1 of the Code of Virginia with the group.

4. **Review of Agenda**

   Mr. Hornsby reviewed the agenda with the Task Force members. There was discussion regarding the official recommendations and the status of the Commissioner's report of the Task Force, the establishment of guiding principles for the State Health Services Plan (SHSP), the presentation of data observations by VDH staff, and the regulatory and legislative process presentation to be delivered by staff.

5. **Review of Meeting Materials**

   Mr. Hornsby reviewed the meeting materials with the Task Force members upon which no task force members had questions.

6. **Approval of Prior Meeting Minutes**

   The Task Force members did not have the meeting minutes from the September 6, 2024, meeting at this point in time. VDH staff stated that meeting minutes would be provided after the break to the Task Force members.

7. **Public Comment Period**

DRAFT

No members of the public signed up for public comment and no State Health Services Plan Task Force member had public comment to give.

8. The State Health Services Plan

8.1. Establishment of Guiding Principles

Mr. Erik Bodin reviewed the current SMFP Guiding Principles and the two guiding principles that had been discussed, but not voted on, by the 2019 SMFP workgroup with the Task Force members. Mr. Bodin replied that these are the five guiding principles that the State Medical Facilities Plan (SMFP) currently have in place, and that while adopting the current principles and the two considered principles would be the easier course for the Task Force members to take, the Task Force has the ability to start from a clean slate when creating and adopting guiding principles.

Mr. Desjadon asked if it is possible for VDH staff to provide minutes or information from the 2019 SMFP workgroup for context to which VDH staff replied that they would see what records they have from that previous workgroup.

VDH staff replied that they would provide any information from the 2019 SMFP workgroup to the Task Force.

Ms. Carrie Davis questioned if new institutional facilities were a part of the concern around guiding principle 6.

Ms. Karen Cameron stated that those were not traditionally a part of CON, based on her background of knowledge and experience reviewing projects.

The Task Force members discussed concerns with triple aim of care in reference to guiding principles 6 and 7.

Mr. Bodin emphasized that guiding principles 6 and 7 were not adopted into the regulatory process.

Mr. Michael Desjadon asked why the two principles from the previous SMFP workgroup were not adopted.

Mr. Bodin replied that those had been previously advanced for discussion, but that the Task Force was free to come up with their own guiding principles.

Dr. Eppes suggested that the Task Force members think on these guiding principles and make suggestions for adoption at the next SHSP Task Force meeting.

Dr. Marilyn West asked if guiding principles 6 and 7 were items that VDH wanted to add to the current SMFP.

Ms. Shaila Menees asked if this list was exhaustive.

Mr. Bodin replied in the affirmative and stated that if the Task Force members had other options for discussion, VDH staff could create a document for the Task members to review.

DRAFT

Mr. Paul Dreyer emphasized that in establishing these guiding principles, the Task Force is simply building the overarching framework for the State Health Services Plan, but not selecting criteria for COPN review to which Mr. Bodin replied in the affirmative.

Ms. Karen Cameron stated that the Task Force should keep these guiding principles more succinct and keep them broad so that they may be adjusted over time, and that being more specific can cause the Task Force to not be as adept at changing the SHSP over time.

8.2. Presentation of Data for Psychiatric Services & Discussion

Mr. Hornsby presented the data for psychiatric services to the Task Force members. These data showed utilization data for inpatient psychiatric beds in Virginia as well as a comparison of SHSP psychiatric service considerations between Virginia and other CON states.

Ms. Menees asked for clarification on occupancy rate between SFY 2018 and SFY 2022, and whether 61.1% was the current occupancy rate.

Mr. Hornsby specified that this was the average rate of occupancy across the years of provided data.

Ms. Menees asked if there were significant changes over that period of time because of the number of beds likely changing over that period of time.

Mr. Bodin explained that occupancy was fairly flat over the course of those five state fiscal years.

Ms. Cameron stated that Medicaid expansion was during that time period, that more individuals had access to care, and that occupancy rate remaining fairly flat across that period is interesting.

Ms. Menees stated that much of Medicaid care expanded access for psychiatric services was from non-inpatient facilities not regulated by COPN and that the hope for the decrease in pediatric patients was that pediatric patients were being seen in a non-inpatient setting.

Mr. Hedrick asked if the data provided included the state operated psychiatric hospitals to which Mr. Hornsby replied in the negative.

Dr. Eppes asked if the occupancy rate was different geographically across Virginia.

Mr. Bodin replied that there is some variation, but not as great as expected, and that before the next SHSP meeting, he would provide planning district specific data to the Task Force members. Mr. Bodin further stated that licensed bed capacity is not an issue for state hospitals, but rather distribution and staffing, and that the Department of Behavioral Health and Developmental Services (DBHDS) is moving away from inpatient services and toward residential and outpatient psychiatric services as a department.

Dr. Eppes asked if staffing was a problem for new psychiatric facilities.

Ms. Cameron stated that there have been workforce initiatives for licensing in a psychiatric setting.

Mr. Desjadon expressed that a main concern is reimbursement for mental health.

Ms. Menees agreed, stating that Medicaid expansion has helped reimbursement for mental health in a positive direction. Ms. Menees said that the inpatient setting is the least likely for new providers in the workforce to enter into and discussed new facility types for behavioral health that younger individuals would choose over an inpatient setting.

Ms. Cameron mentioned that with an increase in beds, staff at inpatient facilities would be spread even thinner to manage those beds.

Dr. West discussed the criterion of staffing for a COPN project and the concerns with health care workforce development.

Mr. Bodin stated that DCOPN looks at recruitment pages, on some occasions, to determine their ability to recruit staff for a proposed project.

Dr. Eppes asked if its within the purview of the Task Force to recommend more reimbursement for staffing for Medicaid patients.

Ms. Cameron stated that Medicaid reimbursement for psychiatric services has increased greatly and further proposed that a criterion for COPN projects would be how a provider is recruiting for staff in and out of state.

Mr. Desjadon suggested that a recommendation for the General Assembly that improvements can be made in the areas being discussed.

Mr. Hedrick asked if the map displaying 60-minute drive time was for inpatient psychiatric hospitals to which Mr. Bodin replied in the affirmative.

Mr. Bodin discussed the current drive time standard and suggested options for psychiatric services.

Mr. Hornsby stated that only Maryland had a drive time for inpatient psychiatric services which was 45 minutes for pediatric patients and 30 minutes for adult psychiatric patients.

Ms. Davis asked if occupancy was based off of staffed or licensed beds and if VDH can provide percentages of staffed beds in different planning areas to determine true availability of beds in communities.

Mr. Bodin replied that occupancy rates were based off of licensed beds, but that VDH could provide occupancy based off of staffed beds by planning district.

Ms. Cameron asked if some of the impact was because of private room requirements versus semi-private rooms and asked if VDH staff are retrieving staffing information from a facilities licensure report.

Mr. Bodin replied that VDH will retrieve that information from VHI data.

Ms. Dulin asked if other states have different mechanisms for a similar goal regarding region specific considerations and drive time.

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Mr. Hornsby specified that some states have requirements to draw from residents in an area where psychiatric services are being proposed to be offered.

Mr. Dreyer mentioned that there are lots of other criteria and drive time does not necessarily mean that a COPN will be approved.

Dr. Eppes asked what the Task Force should be recommending for the regulatory process for psychiatric services given the data observations provided by VDH staff.

Mr. Bodin asked what other kinds of criteria the Task Force would like to look at for psychiatric care specifically and cautioned against adding additional licensing capacity. Mr. Bodin also discussed current projects and the movement of services within COPN.

The Task Force members discussed how recommendations are made for both legislative and regulatory changes to COPN and asked for the sections of 12VAC5-230 that specify criteria for psychiatric services.

Ms. Menees asked if the Task Force members could see the recommendations they have already put forth for expedited review and psychiatric services and if there is anything in the current criteria that the Task Force may want to modify.

Mr. Bodin said that the current mandate is what criteria go into COPN review, not just whether an item is reviewed through the standard or expedited process.

VDH staff said they would provide the current regulations for psychiatric service criteria to the Task Force members after their request at the break.

Mr. Desjadon asked if there was any data from VDH demonstrating market demand.

Mr. Bodin replied that the closest proxy to demand is occupancy.

The Task Force members discussed data surrounding demand other than drive time and seeking an objective data source to measure availability of services as well as age, socioeconomics, and demographics of individuals receiving inpatient psychiatric care.

Ms. Davis asked if there was a way to recommend new facilities to be private room only because of individual psychiatric patient need.

Ms. Cameron asked if new facilities are seeing private room only building patterns.

Mr. Bodin replied that is the case across all provider types and that VDH staff would look at the Facilities Guidelines Institute (FGI) guidelines to see what proportion of inpatient psychiatric beds require private rooms.

Ms. Menees mentioned that there are pros and cons to having private rooms and that bringing back the Commissioner of DBHDS to discuss this would be a possibility.

The Task Force members discussed finding the balance between regional specific criteria and not making the COPN regulations too onerous for applicants.

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Ms. Menees stated that the process for COPN appears to be working properly in finding that balance for psychiatric service review criteria.

The Task Force members discussed concerns regarding criteria surrounding continuum of care and what the relationship between new facilities and services is with advocacy organizations in an area of a proposed project.

Break

9. Regulatory and Legislative Process Presentation

Mr. Bodin began the presentation by providing background on the legislative process and the regulatory process for the Task Force members. Mr. Bodin specifically discussed the standard regulatory process and how the SHSP has a partial exemption from the Virginia Administrative Process Act (APA) and can put forth regulatory text more quickly than the regular process.

The Task Force members reviewed how they decided to tackle each service of the SHSP by COPN review batching cycle and the timeline for recommendations made by the Task Force on each batch cycle.

Mr. Bodin clarified the difference between “batching” regulatory actions versus the batching cycles of the COPN review process.

Ms. Adams asked what the partial exemption meant for the regulatory process for the SHSP.

Mr. Bodin clarified that the partial exemption has elements of the full process but is not the same as the fast-track regulatory process.

VDH staff were unable to find the specific section of the Code of Virginia containing that exemption, but told the Task Force members that they would provide this information at the next SHSP Task Force meeting.

10. Approval of Meeting Minutes

VDH staff provided the meeting minutes from the September 6, 2024, meeting for the SHSP Task Force members. Ms. Cameron and Ms. Menees had technical grammatical amendments to the meeting minutes. Ms. Cameron motioned the meeting minutes be adopted as amended and Ms. Davis seconded the motion. The minutes were approved without opposition.

11. Wrap-Up and Next Steps

The Task Force discussed the feedback they will provide to VDH staff regarding the establishment of guiding principles and recommendations for criteria for psychiatric services before their next meeting. The Task Force members also reviewed the data requests of VDH staff for the next meeting. The Task Force decided the next several dates for meetings.

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Mr. Bodin stated that the next batching cycles regarding diagnostic imaging will take several meetings to review, and that it will be easier for the Task Force members to break down service by service in terms of recommending criteria.

Mr. Bodin stated that while there are differences in the medical industry in how a CT scanner is utilized, the regulations currently view all CTs as the same.

The Task Force members discussed the ways in which diagnostic imaging services are utilized, in terms of staffing, whether they are used in an inpatient or outpatient setting, whether they are used for diagnostic or therapeutic use, and what industry standards are for diagnostic imaging.

VDH staff stated they will provide data in regard to diagnostic imaging services to assist the Task Force members in making recommendations, but that the organizations that the Task Force members represent may have current industry standards they can provide.

VDH staff reviewed the expiring member terms and explained that VDH will reach out to member organizations about expiring members terms for nominations, which can include current members.

12. Meeting Adjournment

The meeting adjourned at 11:28 a.m.

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Inpatient Psychiatric Bed Utilization, Non-State Beds				FY 2018				FY 2019				FY 2020				FY 2021				FY 2022			
						Occupancy Rate				Occupancy Rate				Occupancy Rate				Occupancy Rate				Occupancy Rate	
Facility Name	HPR	PD	Class	Licensed Beds	Staffed Beds	per Licensed Bed	per Staffed Bed	Licensed Beds	Staffed Beds	per Licensed Bed	per Staffed Bed	Licensed Beds	Staffed Beds	per Licensed Bed	per Staffed Bed	Licensed Beds	Staffed Beds	per Licensed Bed	per Staffed Bed	Licensed Beds	Staffed Beds	per Licensed Bed	per Staffed Bed
Augusta Health	1	6	Psych Bed - Other Adult	28	28	55.1%	55.1%	28	28	67.3%	67.3%	28	28	65.1%	65.1%	28	28	72.8%	72.8%	28	28	62.3%	62.3%
Sentara RMH Medical Center	1	6	Psych Bed - Other Adult	20	20	66.5%	66.5%	20	20	61.3%	61.3%	20	20	58.1%	58.1%	20	20	58.1%	58.1%	20	20	55.8%	55.8%
Valley Health Winchester Medical Center	1	7	Psych Bed - Other Adult	36	36	81.8%	81.8%	36	36	71.6%	71.6%	36	36	66.8%	66.6%	36	36	72.2%	72.2%	36	36	69.7%	69.7%
University of Virginia Medical Center	1	10	Psych Bed - Other Adult	25	25	87.1%	87.1%	25	25	85.7%	85.7%	25	25	81.1%	81.1%	25	25	80.0%	80.0%	25	25	76.6%	76.6%
Mary Washington Hospital	1	16	Psych Bed - Other Adult	42	42	84.3%	84.3%	42	42	83.6%	83.6%	62	62	58.3%	58.3%	62	62	72.3%	72.3%	62	62	60.7%	60.7%
Mary Washington Hospital	1	16	Psych Bed - Other Child	12	12	70.8%	70.8%	12	12	63.3%	63.3%	12	12	59.1%	59.1%	12	12	53.5%	53.5%	12	12	44.0%	44.0%
Spotsylvania Regional Medical Center	1	16	Psych Bed - Other Adult	28	28	63.9%	63.9%	28	28	70.3%	70.3%	28	28	63.2%	63.0%	28	20	56.2%	78.7%	28	20	59.7%	83.6%
HPR I				191	191	74.2%	74.2%	191	191	73.7%	73.7%	211	211	64.0%	64.0%	211	203	68.7%	71.4%	211	203	62.8%	65.3%
Dominion Hospital	2	8	Psych Bed - Psych Adult	46	46	83.0%	83.0%	46	46	95.2%	95.2%	46	46	92.1%	92.1%	46	46	102.0%	102.0%	48	48	98.4%	98.4%
Dominion Hospital	2	8	Psych Bed - Psych Child	70	70	70.6%	70.6%	70	70	66.5%	66.5%	70	70	59.0%	59.0%	70	70	68.5%	68.5%	68	68	63.9%	63.9%
Inova Fairfax Hospital	2	8	Psych Bed - Other Adult	41	41	95.5%	67.6%	41	41	66.6%	66.6%	41	41	71.9%	71.9%	41	41	93.4%	93.4%	41	41	95.1%	95.1%
Inova Fairfax Hospital	2	8	Psych Bed - Other Child	15	15	31.6%	25.3%	15	15	73.8%	73.8%	15	15	82.6%	82.6%	15	15	93.2%	93.2%	15	15	80.2%	80.2%
Inova Loudoun Hospital	2	8	Psych Bed - Other Adult	22	22	64.8%	64.8%	22	22	72.9%	72.9%	22	22	82.4%	82.4%	22	22	81.7%	81.7%	22	22	82.3%	82.3%
Inova Mount Vernon Hospital	2	8	Psych Bed - Other Adult	30	30	73.0%	73.0%	30	30	80.4%	80.4%	30	30	78.8%	78.8%	30	30	86.1%	86.1%	30	30	74.9%	74.9%
North Spring Behavioral Healthcare	2	8	Psych Bed - Psych Child	100	100	71.1%	71.1%	100	100	86.2%	86.2%	100	100	92.5%	92.2%	125	125	82.8%	82.8%	127	127	91.4%	90.0%
Stone Springs Hospital Center	2	8	Psych Bed - Other Adult													17	17	10.3%	10.3%	17	17	76.3%	76.3%
UVA Health Prince William Medical Center	2	8	Psych Bed - Other Adult	32	15	47.6%	101.5%	32	20	64.1%	102.6%	30	22	70.3%	98.1%	30	18	60.0%	100.0%	30	18	51.3%	42.9%
Virginia Hospital Center	2	8	Psych Bed - Other Adult	40	40	77.1%	77.1%	40	40	80.0%	80.0%	40	39	82.6%	82.4%	40	39	78.1%	78.1%	56	39	37.3%	37.3%
HPR II				396	379	71.5%	71.9%	396	384	77.7%	80.1%	394	385	79.6%	81.4%	436	423	79.2%	81.5%	454	425	79.0%	78.1%
Dickenson Community Hospital	3	2	Psych Bed - Other Adult	10	10	70.1%	70.1%	10	10	62.7%	62.7%	10	8	93.0%	93.0%	10	8	83.8%	83.8%	10	6	56.1%	93.5%
Russell County Hospital	3	2	Psych Bed - Other Adult	20	20	60.2%	60.2%	20	17	72.8%	72.8%	20	20	65.0%	65.0%	20	20	56.6%	56.6%	20	16	49.7%	62.1%
Ridgeview Pavilion (Bristol Region)	3	3	Psych Bed - Psych Adult	28	21	42.7%	56.9%	28	20	50.5%	70.7%	28	20	64.9%	64.9%	28	20	78.8%	78.8%	28	24	60.9%	71.1%
Twin County Regional Healthcare	3	3	Psych Bed - Other Adult	14	14	54.9%	54.9%	14	14	47.3%	47.3%	20	12	21.0%	35.0%	20	12	24.5%	40.8%	20	12	34.1%	56.8%
Carilion New River Valley	3	4	Psych Bed - Other Adult	36	35	84.9%	87.3%	36	26	79.4%	109.9%	36	25	57.9%	83.3%	36	19	50.1%	94.9%	36	16	43.9%	98.7%
LewisGale Hospital Pulaski	3	4	Psych Bed - Other Adult					16	11	24.5%	35.6%	16	16	75.4%	75.2%	16	16	79.7%	79.7%	16	13	77.0%	94.8%
Carilion Roanoke Memorial Hospital	3	5	Psych Bed - Other Adult	35	26	78.7%	105.9%	35	21	57.7%	96.2%	43	26	58.7%	97.1%	43	20	44.8%	96.4%	43	21	47.9%	98.0%
Carilion Roanoke Memorial Hospital	3	5	Psych Bed - Other Child	16	13	74.7%	92.0%	16	14	68.9%	78.7%	23	10	38.7%	88.9%	23	10	39.6%	91.0%	23	8	31.6%	90.9%
LewisGale Hospital - Alleghany	3	5	Psych Bed - Other Adult	15	15	83.0%	83.0%	15	15	90.0%	90.0%	15	15	86.4%	86.2%	15	15	87.8%	87.8%	15	15	81.1%	81.1%
LewisGale Medical Center	3	5	Psych Bed - Other Adult	106	106	36.3%	36.3%	106	106	31.1%	31.1%	106	106	27.1%	27.1%	106	106	30.1%	30.1%	106	26	24.2%	98.5%
LewisGale Medical Center	3	5	Psych Bed - Other Child	24	24	36.3%	36.3%	24	24	62.2%	62.2%	24	24	63.7%	63.7%	24	24	65.4%	65.4%	24	15	59.7%	95.5%
Virginia Baptist Hospital	3	11	Psych Bed - Other Adult	44	44	82.4%	82.4%	44	44	76.0%	76.0%	44	44	65.1%	65.1%	44	44	61.7%	61.7%	44	44	63.6%	63.6%
Virginia Baptist Hospital	3	11	Psych Bed - Other Child	20	20	58.1%	58.1%	20	20	63.4%	63.4%	20	20	52.8%	52.8%	20	20	53.2%	53.2%	20	20	51.8%	51.8%
Sovah Health - Danville	3	12	Psych Bed - Other Adult	25	19	27.8%	36.5%	25	19	32.7%	43.1%	25	19	39.5%	51.9%	25	19	44.7%	58.8%	25	19	64.0%	64.0%
Sovah Health - Martinsville	3	12	Psych Bed - Other Adult	12	12	64.3%	64.3%	12	12	70.3%	70.3%	12	12	70.8%	70.8%	12	12	67.3%	67.3%	12	12	66.9%	66.9%
HPR III				405	379	57.0%	60.9%	421	373	54.4%	60.9%	442	377	50.7%	58.1%	442	365	49.9%	59.1%	442	267	47.3%	77.2%
Bon Secours Richmond Community Hospital	4	15	Psych Bed - Other Adult	40	40	54.4%	54.4%	40	40	53.1%	53.1%	40	40	50.0%	50.0%	40	40	62.0%	62.0%	40	40	64.1%	64.1%
Bon Secours St. Mary's Hospital	4	15	Psych Bed - Other Adult	32	32	71.8%	71.8%	32	32	68.5%	68.5%	32	32	64.1%	64.1%	32	32	66.3%	66.3%	32	32	58.5%	58.5%
Chippenham Hospital	4	15	Psych Bed - Other Adult	113	113	74.3%	74.3%	113	113	74.3%	74.3%	113	113	59.5%	59.5%	90	90	54.9%	54.9%	113	113	60.4%	60.4%
Chippenham Hospital	4	15	Psych Bed - Other Child	24	24	59.3%	59.3%	24	24	65.6%	65.6%	24	24	66.2%	66.2%	24	24	73.5%	73.5%	24	24	66.6%	66.6%
Cumberland Hospital for Children and Adolescents	4	15	Psych Bed - Other Child													16	16	22.7%	22.7%	16	12	49.1%	65.5%
Henrico Doctor's Hospital - Parham Doctors' Hospital	4	15	Psych Bed - Other Adult	24	24	71.3%	71.3%	24	24	77.1%	77.1%	24	24	78.1%	78.1%	24	24	74.3%	74.3%	24	24	66.2%	66.2%
Henrico Doctor's Hospital - Retreat	4	15	Psych Bed - Other Adult	20	20	73.2%	73.2%	20	20	83.4%	83.4%	20	20	23.4%	23.4%	20	20	77.8%	77.8%	20	20	83.8%	83.8%
VCU Medical Center	4	15	Psych Bed - Other Adult	45	40	79.0%	79.0%	45	40	70.0%	70.0%	45	40	73.1%	82.3%	45	40	78.6%	78.6%	45	36	64.6%	80.7%
VCU Medical Center	4	15	Psych Bed - Other Child	32	24	68.1%	68.1%	32	32	64.6%	64.6%	32	32	72.7%	72.7%	32	32	73.7%	73.7%	32	16	49.7%	99.4%
Bon Secours Southern Virginia Medical Center	4	19	Psych Bed - Other Adult	10	10	66.9%	66.9%	10	10	82.6%	82.6%	10	10	7.4%	7.4%	10	10	64.0%	64.0%	10	10	49.8%	49.8%
Bon Secours Southside Medical Center	4	19	Psych Bed - Other Adult	30	30	77.4%	77.4%	30	30	84.9%	84.9%	30	30	88.3%	88.0%	30	30	71.1%	71.1%	30	30	63.8%	63.8%
Poplar Springs Hospital	4	19	Psych Bed - Psych Adult	83	64	77.9%	77.9%	83	80	80.1%	83.1%	84	53	59.0%	93.5%	84	75	64.4%	72.2%	84	81	82.0%	81.6%
Poplar Springs Hospital	4	19	Psych Bed - Psych Child	125	106	47.1%	55.6%	125	92	44.3%	60.2%	124	72	49.1%	84.6%	124	98	48.6%	61.5%	124	87	70.2%	70.6%
TriCities Hospital	4	19	Psych Bed - Other Adult	40	40	74.9%	74.9%	40	40	80.8%	80.8%	40	40	83.1%	83.1%	40	40	70.4%	70.6%	40	40	60.2%	60.2%
HPR IV				618	567	66.8%	69.0%	618	577	67.6%	71.8%	618	530	60.5%	70.6%	611	571	62.0%	65.8%	634	565	65.6%	69.0%
Bon Secours Rappahannock General Hospital	5	17	Psych Bed - Other Adult	10	8	50.2%	62.7%	10	8	49.1%	61.6%	10	10	41.5%	41.4%	10	10	55.5%	55.5%	10	10	52.6%	52.6%
Bon Secours Maryview Medical Center	5	20	Psych Bed - Other Adult	12	12	28.7%	28.7%	42	34	50.9%	62.8%	42	34	39.0%	48.1%	54	46	28.3%	33.2%	54	16	24.7%	83.2%
Bon Secours Maryview Medical Center	5	20	Psych Bed - Other Child	42	38	51.5%	51.5%	12	12	32.4%	32.4%		12	14.8%	14.8%					12			
Chesapeake Regional Medical Center	5	20	Psych Bed - Other Adult													10	0	0.0%		20	0	0.0%	
Kempsville Center for Behavioral Health	5	20	Psych Bed - Psych Child	82	82	82.9%	82.9%	82	82	82.2%	82.2%	82	82	75.6%	75.6%	82	82	80.6%	80.6%	106	106	73.4%	62.3%
Sentara Norfolk General Hospital	5	20	Psych Bed - Other Adult	34	28	80.1%	80.1%	34	26	90.2%	90.2%	34	26	51.2%	67.0%	34	26	62.7%	82.0%	34	25	62.8%	85.4%
Sentara Obici Hospital	5	20	Psych Bed - Other Adult	20	20	59.3%	59.3%	20	20	62.6%	62.6%	20	20	56.9%	56.9%	20	20	60.5%	60.5%	20	20	59.1%	59.1%
Sentara Virginia Beach General Hospital	5	20	Psych Bed - Other Adult	24	24	80.9%	80.9%	24	24	84.1%	84.1%	24	24	76.5%	76.5%	24	22	81.7%	89.2%	24	20	79.3%	95.2%
Virginia Beach Psychiatric Center	5	20	Psych Bed - Psych Adult	100	100	7.5%	75.5%	100	100	71.2%	71.2%	100	100	64.1%	64.1%	100	100	66.1%	66.1%	100	100	66.6%	66.6%
Newport News Behavioral Health Center	5	21	Psych Bed - Psych Child	132	132	147.0%	147.0%	132	132	72.7%	72.7%	132	132	70.5%	70.3%	132	132	54.7%	54.7%	132	132	49.2%	49.2%
Riverside Regional Medical Center	5	21	Psych Bed - Other Adult	58	34	57.7%	98.5%	58	34	58.4%	99.6%	58	34	57.4%	97.8%	78	35	58.8%	97.5%	78	44	55.2%	97.8%
Riverside Regional Medical Center	5	21	Psych Bed - Other Child	68	31	45.5%	99.7%	68	31	45.3%	99.3%	68	28	40.3%	97.8%	20	17	24.9%	99.6%	20	11	54.4%	99.0%
The Pavilion at Williamsburg Place	5	21	Psych Bed - Psych Adult					66	66	79.0%	79.0%	66	66	84.1%	83.9%	66	61	83.1%	83.0%	66	66	88.4%	88.4%
HPR V				582	509	32.9%	95.0%	648	569	68.4%	76.9%	636	568	62.5%	71.4%	630	551	58.3%	68.9%	676	550	58.7%	69.2%
State Wide				2,192	2,025	50.1%	75.1%	2,274	2,094	67.7%	73.0%	2,301	2,071	62.8%	69.8%	2,330	2,113	62.5%	69.1%	2,417	2,010	62.4%	71.7%

Trend: per Licensed Bed, per Staffed Bed

Blue Bold = change in number of beds from prior year
Red = decrease in occupancy rate from prior year

Inpatient Psychiatric Bed Utilization, Non-State Beds				FY 2018		Occupancy Rate		FY 2019		Occupancy Rate		FY 2020		Occupancy Rate		FY 2021		Occupancy Rate		FY 2022		Occupancy Rate		Trend	
Facility Name	HPR	PD	Class	Licensed Beds	Staffed Beds	per Licensed Bed	per Staffed Bed	Licensed Beds	Staffed Beds	per Licensed Bed	per Staffed Bed	Licensed Beds	Staffed Beds	per Licensed Bed	per Staffed Bed	Licensed Beds	Staffed Beds	per Licensed Bed	per Staffed Bed	Licensed Beds	Staffed Beds	per Licensed Bed	per Staffed Bed	per Licensed Bed	per Staffed Bed
Augusta Health	1	6	Psych Bed - Other Adult	28	28	55.1%	55.1%	28	28	67.3%	67.3%	28	28	65.1%	65.1%	28	28	72.8%	72.8%	28	28	62.3%	62.3%		
Sentara RMH Medical Center	1	6	Psych Bed - Other Adult	20	20	66.5%	66.5%	20	20	61.3%	61.3%	20	20	58.1%	58.1%	20	20	58.1%	58.1%	20	20	55.8%	55.8%		
Valley Health Winchester Medical Center	1	7	Psych Bed - Other Adult	36	36	81.8%	81.8%	36	36	71.6%	71.6%	36	36	66.8%	66.6%	36	36	72.2%	72.2%	36	36	69.7%	69.7%		
University of Virginia Medical Center	1	10	Psych Bed - Other Adult	25	25	87.1%	87.1%	25	25	85.7%	85.7%	25	25	81.1%	81.1%	25	25	80.0%	80.0%	25	25	76.6%	76.6%		
Mary Washington Hospital	1	16	Psych Bed - Other Adult	42	42	84.3%	84.3%	42	42	83.6%	83.6%	62	62	58.3%	58.3%	62	62	72.3%	72.3%	62	62	60.7%	60.7%		
Mary Washington Hospital	1	16	Psych Bed - Other Child	12	12	70.8%	70.8%	12	12	63.3%	63.3%	12	12	59.1%	59.1%	12	12	53.5%	53.5%	12	12	44.0%	44.0%		
Spotsylvania Regional Medical Center	1	16	Psych Bed - Other Adult	28	28	63.9%	63.9%	28	28	70.3%	70.3%	28	28	63.2%	63.0%	28	20	56.2%	78.7%	28	20	59.7%	83.6%		
HPR I				191	191	74.2%	74.2%	191	191	73.7%	73.7%	211	211	64.0%	64.0%	211	203	68.7%	71.4%	211	203	62.8%	65.3%		
Dominion Hospital	2	8	Psych Bed - Psych Adult	46	46	83.0%	83.0%	46	46	95.2%	95.2%	46	46	92.1%	92.1%	46	46	102.0%	102.0%	48	48	98.4%	98.4%		
Dominion Hospital	2	8	Psych Bed - Psych Child	70	70	70.6%	70.6%	70	70	66.5%	66.5%	70	70	59.0%	59.0%	70	70	68.5%	68.5%	68	68	63.9%	63.9%		
Inova Fairfax Hospital	2	8	Psych Bed - Other Adult	41	41	95.5%	67.6%	41	41	66.6%	66.6%	41	41	71.9%	71.9%	41	41	93.4%	93.4%	41	41	95.1%	95.1%		
Inova Fairfax Hospital	2	8	Psych Bed - Other Child	15	15	31.6%	25.3%	15	15	73.8%	73.8%	15	15	82.6%	82.6%	15	15	93.2%	93.2%	15	15	80.2%	80.2%		
Inova Loudoun Hospital	2	8	Psych Bed - Other Adult	22	22	64.8%	64.8%	22	22	72.9%	72.9%	22	22	82.4%	82.4%	22	22	81.7%	81.7%	22	22	82.3%	82.3%		
Inova Mount Vernon Hospital	2	8	Psych Bed - Other Adult	30	30	73.0%	73.0%	30	30	80.4%	80.4%	30	30	78.8%	78.8%	30	30	86.1%	86.1%	30	30	74.9%	74.9%		
North Spring Behavioral Healthcare	2	8	Psych Bed - Psych Child	100	100	71.1%	71.1%	100	100	86.2%	86.2%	100	100	92.5%	92.2%	125	125	82.8%	82.8%	127	127	91.4%	90.0%		
Stone Springs Hospital Center	2	8	Psych Bed - Other Adult													17	17	10.3%	10.3%	17	17	76.3%	76.3%		
UVA Health Prince William Medical Center	2	8	Psych Bed - Other Adult	32	15	47.6%	101.5%	32	20	64.1%	102.6%	30	22	70.3%	98.1%	30	18	60.0%	100.0%	30	18	51.3%	42.9%		
Virginia Hospital Center	2	8	Psych Bed - Other Adult	40	40	77.1%	77.1%	40	40	80.0%	80.0%	40	39	82.6%	82.4%	40	39	78.1%	78.1%	56	39	37.3%	37.3%		
HPR II				396	379	71.5%	71.9%	396	384	77.7%	80.1%	394	385	79.6%	81.4%	436	423	79.2%	81.5%	454	425	79.0%	78.1%		
Dickenson Community Hospital	3	2	Psych Bed - Other Adult	10	10	70.1%	70.1%	10	10	62.7%	62.7%	10	8	93.0%	93.0%	10	8	83.8%	83.8%	10	6	56.1%	93.5%		
Russell County Hospital	3	2	Psych Bed - Other Adult	20	20	60.2%	60.2%	20	17	72.8%	72.8%	20	20	65.0%	65.0%	20	20	56.6%	56.6%	20	16	49.7%	62.1%		
Ridgeview Pavilion (Bristol Region)	3	3	Psych Bed - Psych Adult	28	21	42.7%	56.9%	28	20	50.5%	70.7%	28	20	64.9%	64.9%	28	20	78.8%	78.8%	28	24	60.9%	71.1%		
Twin County Regional Healthcare	3	3	Psych Bed - Other Adult	14	14	54.9%	54.9%	14	14	47.3%	47.3%	20	12	21.0%	35.0%	20	12	24.5%	40.8%	20	12	34.1%	56.8%		
Carilion New River Valley	3	4	Psych Bed - Other Adult	36	35	84.9%	87.3%	36	26	79.4%	109.9%	36	25	57.9%	83.3%	36	19	50.1%	94.9%	36	16	43.9%	98.7%		
LewisGale Hospital Pulaski	3	4	Psych Bed - Other Adult					16	11	24.5%	35.6%	16	16	75.4%	75.2%	16	16	79.7%	79.7%	16	13	77.0%	94.8%		
Carilion Roanoke Memorial Hospital	3	5	Psych Bed - Other Adult	35	26	78.7%	105.9%	35	21	57.7%	96.2%	43	26	58.7%	97.1%	43	20	44.8%	96.4%	43	21	47.9%	98.0%		
Carilion Roanoke Memorial Hospital	3	5	Psych Bed - Other Child	16	13	74.7%	92.0%	16	14	68.9%	78.7%	23	10	38.7%	88.9%	23	10	39.6%	91.0%	23	8	31.6%	90.9%		
LewisGale Hospital - Alleghany	3	5	Psych Bed - Other Adult	15	15	83.0%	83.0%	15	15	90.0%	90.0%	15	15	86.4%	86.2%	15	15	87.8%	87.8%	15	15	81.1%	81.1%		
LewisGale Medical Center	3	5	Psych Bed - Other Adult	106	106	36.3%	36.3%	106	106	31.1%	31.1%	106	106	27.1%	27.1%	106	106	30.1%	30.1%	106	26	24.2%	98.5%		
LewisGale Medical Center	3	5	Psych Bed - Other Child	24	24	36.3%	36.3%	24	24	62.2%	62.2%	24	24	63.7%	63.7%	24	24	65.4%	65.4%	24	15	59.7%	95.5%		
Virginia Baptist Hospital	3	11	Psych Bed - Other Adult	44	44	82.4%	82.4%	44	44	76.0%	76.0%	44	44	65.1%	65.1%	44	44	61.7%	61.7%	44	44	63.6%	63.6%		
Virginia Baptist Hospital	3	11	Psych Bed - Other Child	20	20	58.1%	58.1%	20	20	63.4%	63.4%	20	20	52.8%	52.8%	20	20	53.2%	53.2%	20	20	51.8%	51.8%		
Sovah Health - Danville	3	12	Psych Bed - Other Adult	25	19	27.8%	36.5%	25	19	32.7%	43.1%	25	19	39.5%	51.9%	25	19	44.7%	58.8%	25	19	64.0%	64.0%		
Sovah Health - Martinsville	3	12	Psych Bed - Other Adult	12	12	64.3%	64.3%	12	12	70.3%	70.3%	12	12	70.8%	70.8%	12	12	67.3%	67.3%	12	12	66.9%	66.9%		
HPR III				405	379	57.0%	60.9%	421	373	54.4%	60.9%	442	377	50.7%	58.1%	442	365	49.9%	59.1%	442	267	47.3%	77.2%		
Bon Secours Richmond Community Hospital	4	15	Psych Bed - Other Adult	40	40	54.4%	54.4%	40	40	53.1%	53.1%	40	40	50.0%	50.0%	40	40	62.0%	62.0%	40	40	64.1%	64.1%		
Bon Secours St. Mary's Hospital	4	15	Psych Bed - Other Adult	32	32	71.8%	71.8%	32	32	68.5%	68.5%	32	32	64.1%	64.1%	32	32	66.3%	66.3%	32	32	58.5%	58.5%		
Chippenham Hospital	4	15	Psych Bed - Other Adult	113	113	74.3%	74.3%	113	113	74.3%	74.3%	113	113	59.5%	59.5%	90	90	54.9%	54.9%	113	113	60.4%	60.4%		
Chippenham Hospital	4	15	Psych Bed - Other Child	24	24	59.3%	59.3%	24	24	65.6%	65.6%	24	24	66.2%	66.2%	24	24	73.5%	73.5%	24	24	66.6%	66.6%		
Cumberland Hospital for Children and Adolescents	4	15	Psych Bed - Other Child													16	16	22.7%	22.7%	16	12	49.1%	65.5%		
Henrico Doctor's Hospital - Parham Doctors' Hospital	4	15	Psych Bed - Other Adult	24	24	71.3%	71.3%	24	24	77.1%	77.1%	24	24	78.1%	78.1%	24	24	74.3%	74.3%	24	24	66.2%	66.2%		
Henrico Doctor's Hospital - Retreat	4	15	Psych Bed - Other Adult	20	20	73.2%	73.2%	20	20	83.4%	83.4%	20	20	73.4%	73.4%	20	20	77.8%	77.8%	20	20	83.8%	83.8%		
VCU Medical Center	4	15	Psych Bed - Other Adult	45	40	79.0%	79.0%	45	40	70.0%	70.0%	45	40	73.1%	82.3%	45	40	78.6%	78.6%	45	36	64.6%	80.7%		
VCU Medical Center	4	15	Psych Bed - Other Child	32	24	68.1%	68.1%	32	32	64.6%	64.6%	32	32	72.7%	72.7%	32	32	73.7%	73.7%	32	16	49.7%	99.4%		
Bon Secours Southern Virginia Medical Center	4	19	Psych Bed - Other Adult	10	10	66.9%	66.9%	10	10	82.6%	82.6%	10	10	7.4%	7.4%	10	10	64.0%	64.0%	10	10	49.8%	49.8%		
Bon Secours Southside Medical Center	4	19	Psych Bed - Other Adult	30	30	77.4%	77.4%	30	30	84.9%	84.9%	30	30	88.3%	88.0%	30	30	71.1%	71.1%	30	30	63.8%	63.8%		
Poplar Springs Hospital	4	19	Psych Bed - Psych Adult	83	64	77.9%	77.9%	83	80	80.1%	83.1%	84	53	59.0%	93.5%	84	75	64.4%	72.2%	84	81	82.0%	81.6%		
Poplar Springs Hospital	4	19	Psych Bed - Psych Child	125	106	47.1%	55.6%	125	92	44.3%	60.2%	124	72	49.1%	84.6%	124	98	48.6%	61.5%	124	87	70.2%	70.6%		
TriCities Hospital	4	19	Psych Bed - Other Adult	40	40	74.9%	74.9%	40	40	80.8%	80.8%	40	40	83.1%	83.1%	40	40	70.4%	70.6%	40	40	60.2%	60.2%		
HPR IV				618	567	66.8%	69.0%	618	577	67.6%	71.8%	618	530	60.5%	70.6%	611	571	62.0%	65.8%	634	565	65.6%	69.0%		
Bon Secours Rappahannock General Hospital	5	17	Psych Bed - Other Adult	10	8	50.2%	62.7%	10	8	49.3%	61.6%	10	10	41.5%	41.4%	10	10	55.5%	55.5%	10	10	52.6%	52.6%		
Bon Secours Maryview Medical Center	5	20	Psych Bed - Other Adult	12	12	28.7%	28.7%	42	34	50.9%	62.8%	42	34	39.4%	48.1%	54	46	28.3%	33.2%	54	16	24.7%	83.2%		
Bon Secours Maryview Medical Center	5	20	Psych Bed - Other Child	42	38	51.5%	51.5%	12	12	32.4%	32.4%		12	14.8%	14.8%					12					
Chesapeake Regional Medical Center	5	20	Psych Bed - Other Adult													10	0	0.0%		20	0	0.0%			
Kempsville Center for Behavioral Health	5	20	Psych Bed - Psych Child	82	82	82.9%	82.9%	82	82	82.2%	82.2%	82	82	75.6%	75.6%	82	82	80.6%	80.6%	106	106	73.4%	62.3%		
Sentara Norfolk General Hospital	5	20	Psych Bed - Other Adult	34	28	80.1%	80.1%	34	26	90.2%	90.2%	34	26	51.2%	67.0%	34	26	62.7%	82.0%	34	25	62.8%	85.4%		
Sentara Obici Hospital	5	20	Psych Bed - Other Adult	20	20	59.3%	59.3%	20	20	62.6%	62.6%	20	20	56.9%	56.9%	20	20	60.5%	60.5%	20	20	59.1%	59.1%		
Sentara Virginia Beach General Hospital	5	20	Psych Bed - Other Adult	24	24	80.9%	80.9%	24	24	84.1%	84.1%	24	24	76.5%	76.5%	24	22	81.7%	89.2%	24	20	79.3%	95.2%		
Virginia Beach Psychiatric Center	5	20	Psych Bed - Psych Adult	100	100	7.5%	75.5%	100	100	71.2%	71.2%	100	100	64.1%	64.1%	100	100	66.1%	66.1%	100	100	66.6%	66.6%		
Newport News Behavioral Health Center	5	21	Psych Bed - Psych Child	132	132	147.0%	147.0%	132	132	72.7%	72.7%	132	132	70.5%	70.3%	132	132	54.7%	54.7%	132	132	49.2%	49.2%		
Riverside Regional Medical Center	5	21	Psych Bed - Other Adult	58	34	57.7%	98.5%	58	34	58.4%	99.6%	58	34	57.4%	97.8%	78	35	58.8%	97.5%	78	44	55.2%	97.8%		
Riverside Regional Medical Center	5	21	Psych Bed - Other Child	68	31	45.5%	99.7%	68	31	45.3%	99.3%	68	28	40.3%	97.8%	20	17	24.9%	99.6%	20	11	54.4%	99.0%		
The Pavilion at Williamsburg Place	5	21	Psych Bed - Psych Adult					66	66	79.0%	79.0%	66	66	84.1%	83.9%	66	61	83.1%	83.0%	66	66	88.4%	88.4%		
HPR V				582	509	32.9%	95.0%	648	569	68.4%	76.9%	636	568	62.5%	71.4%	630	551	58.3%	68.9%	676	550	58.7%	69.2%		
State Wide				2,192	2,025	50.1%	75.1%	2,274	2,094	67.7%	73.0%	2,301	2,071	62.8%	69.8%	2,330	2,113	62.5%	69.1%	2,417	2,010	62.4%	71.7%		

Blue Bold = change in number of beds from prior year
Red = decrease in occupancy rate from prior year